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ABSTRACT

The chronic mentally ill experience substantially higher rates of HIV infection than the general population. This paper examines the problems which confront the chronic mentally ill and society at large. Discussed are the questions of whether or not psychiatric patients should be excepted, due to their cognitive and behavioral impairments, from the protection of AIDS confidentiality laws. The question is raised that if some mentally ill are excluded, what will be the guiding criteria for exclusions? Also reviewed is the question of involuntary confinement of those infected with HIV and whether or not this is an appropriate way of controlling careless, high risk behavior. Likewise, society faces difficulties with the chronic mentally ill person's capacity to consent to HIV testing. Psychiatrically disabled people may suffer from diminished capacity and thus be unable to make competent decisions based on the HIV test counseling. Finally, although there has been considerable resistance to seeing mentally ill people as sexually active, psychiatric illness does not preclude sexual impulse. The Office of Mental Health drafted a policy on patient sexual activity which demands that condoms be available to psychiatric inpatients unless clinically contraindicated, but the type of condom availability warranted remains undefined. Contains 20 references. (Author/RJM)

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AIDS AND THE CHRONIC MENTALLY ILL: LEGAL AND ETHICAL ISSUES

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Introduction

The chronic mentally ill have substantially higher rates of HIV infection than the general population. Published reports show seroprevalence rates ranging from 5.5% to 19.4% (Zamperetti et al., 1990; Cournos et al., 1991; Volavka et al., 1991; Sacks et al., 1992; Susser et al., 1993) in this population. The large and increasing number of the HIV infected chronic mentally ill raises a number of ethical and legal questions. How do we weigh the necessity for confidentiality against the duty to warn third parties? Should HIV infected patients be involuntary confined? What constitutes capacity to consent to testing? Should we provide condoms to psychiatric inpatients? The impact of the AIDS epidemic raises unique challenges for those committed to the provision of mental health services. How we frame the issues and weigh each factor may reveal much about our personal values and concerns and foretell our proposed resolutions.

Little guidance on these issues is currently provided by the mental hygiene law or the HIV public health law. Until case law provides precedent on these issues, it will be necessary for mental health

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administrators to establish policy in these areas. There are no easy "answers" to these questions. The debate, however, must include a interdisciplinary perspective.

Confidentiality, Relevance of HIV in Assessing Dangerousness and the Duty to Warn Third Parties

Should some or all psychiatric patients be excepted from the protection of AIDS confidentiality laws due to cognitive and behavioral impairments associated with mental illness? If some patients are excepted, what criteria will be used to establish sufficient impairment? What recourse, if any, will patients have to challenge this assessment?

The American Psychiatric Association policy statement on AIDS encourages psychiatrists to warn identifiable third parties of contact with an HIV infected patient. The policy states, "If a patient refuses to agree to change behavior or to notify the person(s) at ongoing risk or if the psychiatrist has good reason to believe that the patient has failed to or is unable to comply with their agreement, it is ethically permissible for the psychiatrist to notify identifiable persons who the psychiatrist believes to be in danger of contracting the virus..." (APA, 1992a). Is this policy a

response to justifiable health concerns or is it prompted primarily by legal considerations (eg. how to avoid liability)? Encouraging patients to take responsibility is important, but what happens when both parties engaging in sexual intercourse are mentally impaired?

Although the APA policy does not apply exclusively to the mentally ill, its application may affect this group more than others. At present, New York State public health law allows a physician to disclose confidential HIV related information to a contact but asserts that "a physician or public health officer shall have no obligation to identify or locate a contact." By replacing the Public Health Law's physician discretion with an unconditional ethical obligation, the APA policy may prove a disincentive for the patient to agree to be tested due to fear of disclosure. In addition, a psychiatrist may not wish to learn the patient's serostatus in order to circumvent the ethical obligation. Zonana (1989) cautions that failure to warn an identifiable third party is likely to be considered negligent, and Perry (1989) points out that the adoption of this ethical guideline makes it likely that it will be transformed into a legal obligation.

Botello, Weinberger, and Gross (1990) propose just that. They suggest legally excepting the mentally ill from the protection afforded by

AIDS confidentiality laws, citing the case of Tarasoff vs. the Regents of the University of Calif., 1976).[1] In justifying the breach of psychotherapist-patient privilege, they quote the Tarasoff court's assertion: "[the] protective privilege ends where the public peril begins." Yet, allowing exceptions set significant, and potentially far-reaching, precedents.

What factors are relevant in assessing patient "dangerousness"? To what extent does our discomfort with sexuality, and particularly the sexuality of the mentally ill, affect our judgment? Does it matter whether the sexual partner of a mentally ill patient is also mentally ill? The AIDS epidemic commands each person to be personally responsible for his/her sexual safety and behavior by assuming that all partners are potentially HIV infected. Therefore, how can any HIV infected person be deemed dangerous to others if everyone is supposed to take HIV transmission safeguards?

Are limitations on HIV confidentiality for the mentally ill justified before there has been a concerted effort to develop programs specifically

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[1]Botello, Weinberger and Gross cite three criteria for making people with mental illness exempt from the HIV confidentiality laws: 1) the patient is aware of his/her HIV-positive serostatus; 2) the patient has a mental disorder; 3) the mental disorder may significantly impair the patient's ability to follow AIDS related safety recommendations. This proposed standard permits breaches of confidentiality based upon the possibility of impairment and thus departs from the legal standard for disabilities which requires an actual showing that the patient presents a significant risk of harm to self or others.

directed at chronic mentally ill communities?[2] Do existing disability civil rights laws require proof that the mentally ill are unable to comprehend the nature of HIV infection and do not take measures to reduce the risk of HIV transmission? If that is the case, published reports on HIV and sex education programs among the mentally ill suggest the contrary. Berman and Rozensky (1984) reported that a course on human sexuality influenced both the sexual knowledge base and attitude toward sexuality of chronic psychiatric patients. Sladyk (1990) reported a significant increase in AIDS knowledge for women in a locked psychiatric unit following a 45-minute lecture on AIDS and safer sexual practices. Carmen and Brady (1990) report attitude and behavior change in psychiatric outpatients attending AIDS "drop-in" groups. Meyer et al. (1992) developed a pilot HIV prevention program specifically for psychiatric inpatients. They conclude that a comprehensive risk reduction program followed by ongoing supportive maintenance groups will have a significant effect on the HIV risk behaviors of the mentally ill.

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[2]A national survey of United States county and state mental hospitals noted that virtually all (99%) provided HIV education to the staff, but only 61% conducted any kind of AIDS education programs for patients. (State Health Reports, 1989).

Involuntary Confinement

Psychiatric facilities may encounter two situations involving confinement of people infected with HIV: those without major psychiatric illness who, despite education, continue to engage in behavior capable of transmitting HIV to others; those who have a major mental illness that impacts on the maintenance of safe behavior following discharge.

Is confinement an appropriate way of controlling careless high risk behavior? Appelbaum (1988) argues that we should recognize the availability of psychiatric commitment as a tool to control the reckless behavior of people who spread the virus. Behavioral management is usually easier in a controlled environment, but is this an appropriate use of a psychiatric hospital? Certainly this departs from the original intent of civil commitment (see Lessard vs. Schmidt, [1972] establishing modern standards of civil commitment).[3] Should people who can function in all other aspects of their lives except for their sexual relationships be confined 24 hours a day?

Confinement of an HIV positive patient who has a major mental

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[3]In Lessard the court defined dangerousness very narrowly: "the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined, he will do immediate harm to himself or others."

illness presents a more complicated problem. The American Psychiatric Association (1992b) AIDS policy for psychiatric inpatients states: "...it is inappropriate to retain the patient in the hospital solely for the purpose of quarantine or preventive detention." What happens when mental illness affects the way a patient understands his or her HIV infection? Should a patient with a delusional belief (that his HIV infection is confined to a Kaposi's sarcoma lesion on his/her arm, and therefore s/he is non-infectious to others) be confined? Can any educational program effectively address this problem?

Capacity to Consent to HIV Testing

New York State's Confidentiality law was designed to insure that the subjects have extensive knowledge of the meaning and implications of their HIV test results. Written consent must be accompanied by extensive pre- and post-test counseling.[4] This system assumes that the individual has the cognitive capacity to understand this complicated information, and then make informed decisions based upon the test results. The hope is that HIV

[4]By law, HIV pre-test counseling must include: an explanation of the test; the purpose of the test; the meaning of the results; benefits of early diagnosis; the voluntary nature of the test; the ability to withdraw consent; advice about the availability of anonymous testing; an explanation of HIV related illness; information about discrimination problems; information about HIV transmission; and counseling or referral for counseling.

positive people will refrain from behavior that might transmit the virus to others, and that HIV negative people will likewise eliminate risky behavior.

The psychiatrically disabled people may, however, suffer from diminished capacity and be unable to make competent decisions based on the HIV test counseling. What criteria should be used to determine competency vis-a-vis HIV testing? To date, mechanisms for HIV counselors to assess a person's capacity to make competent decisions regarding HIV have not been developed. Further complicating this issue is the neurotropic nature of the virus. HIV is capable of causing intellectual dysfunction in otherwise asymptomatic individuals (Navia, Jordan, and Price, 1986). The presenting symptoms of AIDS related dementia can be subtle and may mimic the symptomatology of other psychiatric disorders, especially depression.

The New York State Office of Mental Health includes HIV risk assessment as part of its standard intake evaluation forms. Therefore, knowledge of a risk history may be obtained at a time of crisis. With psychologically unstable patients, sensitivity is essential when opening a discussion of risk history, and recommendations for testing must be made with care. It may be advisable to delay consideration of HIV testing until

the patient can be stabilized.

Access to Condoms

The admission criteria to psychiatric facilities is the evaluation of dangerousness to self or others. The goal of hospitalization is to provide active treatment to enable persons to return to community settings. During the period of hospitalization, sexual activity between patients is discouraged.

Practice does not always conform to policy. We cannot deny that sexual activity occurs within our inpatient facilities. Although there has been considerable resistance to seeing mentally ill people as sexually active, we must realize that psychiatric illness does not preclude sexual impulse.

As a result of these conclusions, the Office of Mental Health has drafted a policy on patient sexual activity that insists that condoms be made available to psychiatric inpatients unless clinically contraindicated. What type of availability is warranted (upon request? voluntary distribution?). The OMH policy, in recognition that patients may be vulnerable to exploitative sexual advances, condemns all sexual contact between patients and staff as patient abuse. When considering sexual

activity by a patient, the treatment team is advised to assess the patient's current mental status, time already spent in the hospital and potential length of stay, the patient's ability to understand his/her rights to consent to or refuse to participate in sexual activity, any medical condition that may have significance to sexual activity, and the patient's level of knowledge of safer sex practices.

This policy also mandates that patients receive sex education and family planning information, instruction on the prevention and treatment of sexually transmitted diseases, and access to protective devices, including condoms.

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